REQUEST FOR PROVIDER RENEWAL

Return this completed form with a check or Money Order for the Renewal fee of **$150** (payable to NHAP) to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

PLEASE PRINT OR TYPE

NAME OF PROVIDER	PROVIDER NUMBER	TELEPHONE NUMBER	
ADDRESS OF RECORD *(STREET AND NUMBER)*	CITY	STATE	ZIP CODE
PROVIDER E-MAIL ADDRESS			

Maintenance of the information requested on this form is authorized by the Health and Safety Code. Signature below certifies this is a renewal of a Continuing Education Provider previously approved within the last two-year period. ***Failure to provide any of the required information will result in the application being rejected as incomplete.***

SIGNATURE OF APPLICANT	DATE
NAME/TITLE	

DO NOT WRITE BELOW THIS LINE

CASH #	AMOUNT	DATE CASHED